CREDENTIALS POLICY

OF

THE NEBRASKA MEDICAL CENTER

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CREDENTIALS POLICY

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ARTICLE 1

GENERAL

1.A. DEFINITIONS

The following definitions shall apply to terms used in this Policy:

(1) "ALLIED HEALTH PROFESSIONALS" ("Allied Health Professionals") means individuals other than Appointees who are authorized by law to provide patient care services, whose scope of practice is defined in the Policy on Allied Health Professionals.

(2) "APPOINTEE" means any physician, dentist, or oral surgeon who has been granted Medical Staff appointment and clinical privileges by the Board to practice at the Hospital.

(3) "BOARD" means the Board of Directors of Nebraska Health System, which has the overall responsibility for the Hospital, or its designated committee.

(4) "BOARD CERTIFICATION" is the designation conferred by: (i) one of the affiliated specialties of the American Board of Medical Specialties ("ABMS"), (ii) the American Osteopathic Association ("AOA"), (iii) the American Board of Oral and Maxillofacial Surgery, (iv) boards recognized by the American Dental Association, or (v) a board of another country recognized by the Medical Staff Executive Committee, upon a physician or dentist who has successfully completed an approved educational training program and an evaluation process, including passing an examination, in the applicant's area of clinical practice.

(5) "CCPPA" means the Chair of Clarkson Private Practice Affairs.

(6) "CHIEF EXECUTIVE OFFICER" ("CEO") means the individual elected by the Board as president.

(7) "CHIEF MEDICAL OFFICER" ("CMO") means the individual appointed by the CEO to act as the chief medical officer of the Hospital pursuant to a general authorization by the Board.

(8) CHIEF NURSING OFFICER (“CNO”) means the individual appointed by the CEO to act as the Vice President of Patient Care Services of the Hospital pursuant to a general authorization by the Board.

(9) "CLINICAL PRIVILEGES" means the authorization granted by the Board to render specific patient care services.

(10) "CREDENTIALS POLICY" means the Hospital's Medical Staff Credentials Policy.

(11) "DAYS" means calendar days.

(12) "DENTIST" means a doctor of dental surgery ("D.D.S.") or doctor of dental medicine ("D.M.D.").

(13) “FULL-TIME ACADEMIC FACULTY CATEGORY” The Full-time Academic Faculty Category of the Active Staff shall be comprised of those Medical Staff appointees who spend more than 25% of their time as academic faculty.

(14) "HOSPITAL" means a hospital that is part of The Nebraska Medical Center.

(15) “HOSPITAL BASED SERVICES” shall mean radiology and nuclear medicine, pathology, radiation- oncology and anesthesiology.

(16) “HOUSE STAFF” means all physicians who are assigned for graduate medical education and will ordinarily carry the title of resident or fellow.

(17) "MEDICAL STAFF" means all physicians, dentists and oral and maxillofacial surgeons who have been appointed to the Medical Staff by the Board.

(18) "MEDICAL STAFF EXECUTIVE COMMITTEE" means the Executive Committee of the Medical Staff.

(19) “MEDICAL STAFF SERVICES” shall be that function of the Hospital assigned to serve the administrative needs of the organized Medical Staff.

(20) “NON HOSPITAL BASED SERVICES” means all Services which are not Hospital Based Services.

(21) "NOTICE" means written communication by regular U.S. mail, e-mail, certified mail, facsimile, or Hospital mail, overnight delivery or hand delivery.

(22) "PHYSICIAN" includes both doctors of medicine ("M.D.s") and doctors of osteopathy ("D.O.s").

(23) “POLICY” shall mean those documents adopted by the Medical Staff Executive Committee and the Board with respect to issues of governance of the Medical Staff.

(24) ‘PRIVATE PRACTICE CATEGORY” The Private Practice Category of the Active Staff shall be comprised of those Medical Staff appointees who spend more than

25% of their professional activity at The Nebraska Medical Center and are not full-time academic physicians.

(25) “SERVICE” shall have that meaning assigned by The Nebraska Medical Center Policy on Medical Staff Organization and Functions.

(26) "UNASSIGNED PATIENT" means any individual who comes to the Hospital for care or treatment and who does not have an attending physician, or whose attending physician or designated alternate is unavailable to attend the patient, or who does not want the prior attending physician to provide him/her care while a patient at the Hospital.

1.B. TIME LIMITS

Time limits referred to in this Policy are advisory only and are not mandatory, unless it is expressly stated that a particular right is waived by failing to take action within a specified period.

1.C. DELEGATION OF FUNCTIONS

When a function is to be carried out by a person or committee, the person, or the committee through its chair, may delegate performance of the function to one or more designees.

ARTICLE 2

QUALIFICATIONS, CONDITIONS AND RESPONSIBILITIES

2.A. QUALIFICATIONS

2.A.1. Eligibility Criteria:

To be eligible to apply for initial appointment or reappointment to the Medical Staff, physicians, dentists, and oral and maxillofacial surgeons must:

(a) have a current unrestricted license to practice in this state and have never had a license to practice revoked or suspended by any state licensing agency;

(b) where applicable to their practice, have a current, unrestricted DEA registration;

(c) be located (office and residence) within the geographic service area of the Hospital, as defined by the Board, close enough to fulfill their Medical Staff responsibilities and to provide timely and continuous care for their patients in the Hospital;

(d) have current, valid professional liability insurance coverage in a form and in amounts satisfactory to the Hospital, except those requesting Courtesy Without Privileges status, Emeritus Staff members who have not requested the right to continue to admit and care for patients and Honorary Staff members;

(e) have never been convicted of Medicare, Medicaid, or other federal or state governmental or private third-party payer fraud or program abuse, nor have been required to pay civil penalties for the same;

(f) have never been, and are not currently, excluded or precluded from participation in Medicare, Medicaid or other federal or state governmental health care program;

(g) have never had Medical Staff appointment or clinical privileges denied, revoked, resigned, relinquished, or terminated by any health care facility or health plan for reasons related to clinical competence or professional conduct;

(h) have never been convicted of, or entered a plea of guilty or no contest to, any felony relating to controlled substances, illegal drugs, insurance or health care fraud or abuse or violence;

(i) have successfully completed a residency training program approved by the Accreditation Council for Graduate Medical Education or the AOA, or a program in another country recognized by the Medical Staff Executive Committee, in a specialty in which the applicant seeks clinical privileges, or an oral and maxillofacial surgery training program accredited by the Commission on Dental Accreditation of the American Dental Association ("ADA"); and

(j) be certified by the appropriate specialty board. Those applicants who are not board certified at the time of application but who have completed their residency training within the last five years shall be eligible for Medical Staff appointment. However, in order to remain eligible, those applicants must achieve board certification within five (5) years from the date of completion of their residency training. (This requirement is applicable only to those individuals who apply for initial staff appointment after October 1, 1997. All individuals appointed previously shall be

governed by the board certification requirements in effect at the time of their appointments.)

2.A.2. Waiver of Criteria:

(a) Any individual who does not satisfy a criterion may request that it be waived. The individual requesting the waiver bears the burden of demonstrating that his or her qualifications are equivalent to, or exceed, the criterion in question.

(b) Requests for waiver of board certification due to international specialty boards will require the individual provide documentation of the following:

i) ECFMG certification

ii) Board specialty certification in a country other than the United States

iii) A comparison of his/her international specialty board training with those of the American Board of Medical Specialties, American Osteopathic Association or American Dental Association with special attention to any deficiencies between his/her training and medical staff accepted board standards.

iv) Letter of support by The Nebraska Medical Center Service Chief or University of Nebraska Medical Center College of Medicine Academic Chairman that specifically addresses any limitations or deficiencies noted in 2.A.2(b)iii.

(c) The Board may grant waivers in exceptional cases after considering the findings of the Credentials Committee, Medical Staff Executive Committee, or other committee designated by the Board, the specific qualifications of the individual in question, and the best interests of the Hospital and the community it serves. The granting of a waiver in a particular case is not intended to set a precedent for any other individual or group of individuals.

(d) No individual is entitled to a waiver or to a hearing if the Board determines not to grant a waiver.

(e) A determination that an individual is not entitled to a waiver is not a "denial" of appointment or clinical privileges.

2.A.3. Factors for Evaluation:

Only those individuals who can document that they are highly qualified in all regards will be appointed to the Medical Staff. The following factors will be evaluated as part of the appointment and reappointment processes:

(a) relevant training, experience, demonstrated current competence and judgment;

(b) adherence to the ethics of their profession;

(c) good reputation and character;

(d) ability to perform, safely and competently, the clinical privileges requested; and

(e) ability to work harmoniously with others sufficiently to convince the Hospital that all patients treated by them will receive quality care and that the Hospital and its Medical Staff will be able to operate in an orderly manner.

2.A.4. No Entitlement to Appointment:

No individual is entitled to receive an application or to be appointed or reappointed to the Medical Staff or to be granted particular clinical privileges merely because he or she:

(a) is licensed to practice a profession in this or any other state;

(b) is a member of any particular professional organization;

(c) has had in the past, or currently has, Medical Staff appointment or privileges at any hospital or health care facility;

(d) resides in the geographic service area of the Hospital; or

(e) is affiliated with, or under contract to, any managed care plan, insurance plan, HMO, PPO, or other entity.

2.A.5. Nondiscrimination:

No individual shall be denied appointment on the basis of gender, race, creed, or national origin.

2.B. GENERAL CONDITIONS OF APPOINTMENT AND REAPPOINTMENT

2.B.1. Basic Responsibilities and Requirements:

As a condition of consideration for appointment or reappointment, and as a condition of continued appointment, every applicant and appointee specifically agree to the following:

(a) to provide continuous and timely care to all patients for whom the individual has responsibility;

(b) to abide by all Bylaws, Policies, and Rules and Regulations of the Hospital and Medical Staff in force during the time the individual is appointed;

(c) to accept committee assignments, emergency service call obligations, and such other reasonable duties and responsibilities as assigned;

(d) to provide, with or without request, new or updated information to Medical Staff Services as it occurs, pertinent to any question on the application form;

(e) to acknowledge that the individual has had an opportunity to read a copy of this Policy and any other applicable Bylaws, Policies, Rules and Regulations and agrees to be bound by them;

(f) to appear for personal interviews in regard to an application for initial appointment or reappointment;

(g) to use the Hospital sufficiently to allow continuing assessment of current competence;

(h) to refrain from illegal fee splitting or other illegal inducements relating to patient referral;

(i) to provide for professional coverage when unavailable;

(j) to refrain from delegating responsibility for hospitalized patients to any individual who is not qualified or adequately supervised;

(k) to refrain from deceiving patients as to the identity of any individual providing treatment or services;

(l) to seek consultation whenever necessary;

(m) to participate in monitoring and evaluation activities;

(n) to complete in a timely manner all medical and other required records, containing all information required by the Hospital;

(o) effective as of the date of appointment, to become a participant in an Organized Health Care Arrangement with the Hospital and as part of the Organized Health Care Arrangement, each Medical Staff Appointee and any other individual exercising clinical privileges in the Hospital will provide patients with a Notice of Organized Health Care Arrangement as a supplement to their own Notice of

Privacy Practices and to comply with any federal or state laws or Hospital policies related to the use or disclosure of individually identifiable health information, including but not limited to the HIPAA Privacy Regulations at 45 C.F.R. Parts 160 and 164;

(p) to perform all services and conduct himself/herself at all times in a cooperative and professional manner;

(q) to promptly pay any applicable dues and assessments;

(r) to satisfy continuing medical education requirements as required by State licensure**;**

(s) to comply with completion of a criminal background check, when requested; and

(t) that, if there is any misstatement in, or omission from, the application, the Hospital may stop processing the application (or, if appointment has been granted prior to the discovery of a misstatement or omission, appointment and privileges may be deemed to be automatically relinquished). In either situation, there shall be no entitlement to a hearing or appeal.

2.B.2. Burden of Providing Information:

(a) Individuals seeking appointment and reappointment have the burden of producing information deemed adequate by the Hospital for a proper evaluation of current competence, character, ethics, and other qualifications and for resolving any doubts.

(b) Individuals seeking appointment and reappointment have the burden of providing evidence that all the statements made and information given on the application are accurate.

(c) An application shall be complete when all questions on the application form have been answered, all supporting documentation has been supplied, and all information has been verified from primary sources. An application shall become incomplete if the need arises for new, additional, or clarifying information at any time. Any application that continues to be incomplete 30 days after the individual has been notified of the additional information required shall be deemed to be withdrawn.

(d) The individual seeking appointment or reappointment is responsible for providing a complete application, including adequate responses from references. An incomplete application will not be processed.

2.C. APPLICATION

2.C.1. Information:

(a) Applications for appointment and reappointment shall contain a request for specific clinical privileges and shall require detailed information concerning the individual's professional qualifications. The applications for initial appointment and reappointment existing now and as may be revised are incorporated by reference and made a part of this Policy.

(b) In addition to other information, the applications shall seek the following:

(1) information as to whether the applicant's Medical Staff appointment or clinical privileges have been voluntarily or involuntarily relinquished, withdrawn, denied, revoked, suspended, subjected to probationary or other conditions, reduced, limited, terminated, or not renewed at any other hospital or health care facility or are currently being investigated or challenged;

(2) information as to whether the applicant's license to practice any relevant profession in any state, DEA registration, or any state's controlled substance license has been voluntarily or involuntarily suspended, modified, terminated, restricted, or relinquished or is currently being investigated or challenged;

(3) information concerning the applicant's professional liability litigation experience, including past and pending claims, final judgments, or settlements; the substance of the allegations as well as the findings and the ultimate disposition; and any additional information concerning such proceedings or actions as the Credentials Committee, the Medical Staff Executive Committee, or the Board may request; and

(4) current information regarding the applicant's ability to safely and competently exercise the clinical privileges requested as obtained through peer review, references and hospital affiliation information.

(c) The applicant shall sign the application and certify that he or she is able to perform the privileges requested and the responsibilities of appointment.

2.C.2. Grant of Immunity and Authorization to Obtain/Release Information:

By applying for appointment, reappointment, or clinical privileges, the applicant expressly accepts the following conditions during the processing and consideration of the application, whether or not appointment or clinical privileges are granted, and throughout the term of any appointment or reappointment.

(a) Immunity:

To the fullest extent permitted by law, the individual releases from any and all liability, extends absolute immunity to, and agrees not to sue the Hospital, any Appointee of the Medical Staff, their authorized representatives, and appropriate third parties for any matter relating to appointment, reappointment, clinical privileges, or the individual's qualifications for the same. This includes any actions, recommendations, reports, statements, communications, or disclosures involving the individual which are made, taken, or received by the Hospital, its authorized agents, or appropriate third parties.

(b) Authorization to Obtain Information from Third Parties:

The individual specifically authorizes the Hospital, The Medical Staff, and their representatives (1) to consult with any third party who may have information bearing on the individual's professional qualifications, credentials, clinical competence, character, ability to perform safely and competently, ethics, behavior, or any other matter reasonably having a bearing on his or her qualifications for initial and continued appointment to the Medical Staff, and (2) to obtain any and all communications, reports, records, statements, documents, recommendations or disclosures of third parties that may be relevant to such questions. The individual also specifically authorizes third parties to release this information to the Hospital and its representatives upon request.

(c) Authorization to Release Information to Third Parties:

The individual also authorizes the Hospital and its representatives to release information to other hospitals, health care facilities, managed care organizations, and their agents when information is requested in order to evaluate his or her professional qualifications for appointment, privileges, and/or participation at the requesting organization/facility.

(d) Hearing and Appeal Procedures:

The individual agrees that the hearing and appeal procedures set forth in this Policy shall be the sole and exclusive remedy with respect to any professional review action taken by the Hospital.

(e) Authorization to Share Information among Affiliates of the Hospital:

The individual specifically authorizes the Hospital and its Affiliates to share credentialing and peer review information among them pertaining to the individual's clinical competence and/or professional conduct. This information may be shared at initial appointment or reappointment and at any other time during the individual's appointment. For purposes of this Section 2.C.2(e), an Affiliate shall be deemed to include but not be limited to Medical Staff Appointees, and their employers, employees and agents and shall specifically include the University of Nebraska College of Medicine, University of Nebraska Medical Center Physicians and Private Practice Associates, LLC.

ARTICLE 3

PROCEDURE FOR INITIAL APPOINTMENT

3.A. PROCEDURE FOR INITIAL APPOINTMENT

3.A.1. Request for Application:

(a) Applications for appointment shall be in writing and shall be on forms approved by the Board upon recommendation by the Medical Staff Executive Committee and Credentials Committee. These forms shall be obtained from the Nebraska Credentials Verification Organization (the local centralized verification

organization) or Medical Staff Services, acting on behalf of the Chief Executive Officer.

(b) An individual seeking initial appointment shall be sent a letter that outlines the eligibility criteria for appointment and the applicable criteria for clinical privileges, and the application form.

(c) Applications may be provided to residents who are in the final six months of their training. Final action will not be taken until all applicable eligibility criteria are satisfied.

3.A.2. Initial Review of Application:

(a) A completed application form with copies of all required documents must be returned to Medical Staff Services within 30 days after receipt. The application must be accompanied by the application fee.

(b) As a preliminary step, the application will be reviewed by Medical Staff Services to determine that all questions have been answered and that the individual satisfies all threshold criteria. Incomplete applications will not be processed. Individuals who fail to return completed applications or fail to meet the threshold criteria will be notified that their application will not be processed.

(c) Medical Staff Services shall oversee the process of gathering and verifying relevant information, and confirming that all references and other information or materials deemed pertinent have been received.

3.A.3. Steps to Be Followed for All Initial Applicants:

(a) Evidence of the applicant's character, professional competence, qualifications, behavior, and ethical standing shall be examined. This information may be contained in the application, and obtained from references and other available sources, including the applicant's past or current department chiefs at other health care entities, residency training director, and others who may have knowledge about the applicant's education, training, experience, and ability to work with others.

(b) An interview with the applicant may be conducted. The purpose of the interview is to discuss and review any aspect of the applicant's application, qualifications, and requested clinical privileges. This interview may be conducted by a combination of any of the following: the Service chief, a Credentials Committee representative, the Credentials Committee, the Chief Medical Officer or the Chief of Staff.

3.A.4. Service Chief Procedure:

(a) The Chief Executive Officer shall transmit the complete application and all supporting materials to the chief of each Service in which the applicant seeks clinical privileges. Each chief shall prepare a written report regarding whether the applicant has satisfied all of the qualifications for appointment and the clinical privileges requested.

(b) The Service chief may also recommend that an application raises no questions and should be considered for expedited processing.

(c) The Service chief shall be available to the Credentials Committee, Medical Staff Executive Committee or the Board to answer any questions that may be raised with respect to that chief's report and findings.

3.A.5. Expedited Process:

(a) If recommended by the relevant Service chief, applications for initial appointment may be processed as set forth in this Section so long as they meet the following conditions:

(1) the applicant has successfully completed a residency in the specialty for which privileges are requested, with a consistent and excellent record, with no disciplinary actions taken or conditions imposed during residency training;

(2) the applicant has not changed practice locations more than three times in the past 10 years;

(3) all reference evaluations are completed and received within a reasonable time of the initial request;

(4) all references contain only favorable evaluations, including unqualified recommendations for appointment and clinical privileges;

(5) the applicant's claims activity (including past malpractice claims and settlements) is reasonable in light of his or her specialty;

(6) there are no current or previously successful challenges to licensure or registration;

(7) there has been no involuntary termination, limitation, restriction, reduction, denial or loss of Medical Staff appointment or clinical privileges at any hospital or other entity;

(8) there has been no investigation into and no disciplinary action taken relating to appointment or clinical privileges at any hospital or other entity; and

(9) no appointee to the Medical Staff has raised a question about the applicant's qualifications.

(b) The Chair of the Credentials Committee, acting on behalf of the Committee, shall review the report from each Service chief and all relevant information and prepare a report containing a recommendation on appointment, clinical privileges, and service assignment. This report shall be forwarded to the Chief of Staff.

(c) The Chief of Staff shall review the report and recommendation made by the Chair of the Credentials Committee. If the Chief of Staff concurs with the recommendation, the recommendation shall be forwarded to the Chief Executive Officer.

(d) The Chief Executive Officer or his designee, may grant the individual temporary clinical privileges, for a period not to exceed 120 days.

(e) After determining that an applicant is otherwise qualified for appointment and privileges, the Chair of the Credentials Committee shall review the applicant's documentation of competency and privilege request form to determine if there is any question about the applicant's ability to perform the privileges requested and the responsibilities of appointment. If there is no question, the temporary privileges shall take effect. If there is a question, the application shall be referred to the full Credentials Committee.

(f) If the Service chief, the chair of the Credentials Committee, the Chief of Staff, or the Chief Executive Officer has any questions about the applicant, the questions shall be noted and the matter shall be referred to the full Credentials Committee for further action.

(g) A report regarding all applicants who are granted temporary clinical privileges shall be forwarded to the Credentials Committee for information, and the application for appointment and clinical privileges shall be forwarded to the Medical Staff Executive Committee for review and recommendation and to the Board for final action.

3.A.6. Full Credentials Committee Procedure:

(a) For all other applications, the Credentials Committee shall review and consider the report prepared by the relevant Service chief and shall make a recommendation. The recommendation shall follow such groupings and criteria s the Board may specify.

(b) The Credentials Committee may use the expertise of the Service chief, or any member of the Service, or an outside consultant, if additional information is required regarding the applicant's qualifications.

(c) After determining that an applicant is otherwise qualified for appointment and privileges, the Credentials Committee shall review the applicant's documentation of competence and privilege request to determine if there is any question about the applicant's ability to perform the privileges requested and the responsibilities of appointment. If so, the Credentials Committee may require the applicant to undergo a physical and/or mental examination by a physician(s) satisfactory to the Credentials Committee. The results of this examination shall be made available to the Committee for its consideration. Failure of an applicant to undergo an examination within a reasonable time after being requested to do so in writing by the Credentials Committee shall be considered a voluntary withdrawal of the application and all processing of the application shall cease.

(d) The Credentials Committee may recommend the imposition of specific conditions. These conditions may relate to behavior (e.g., code of conduct) or to clinical issues

(e.g., general consultation requirements, proctoring). The Credentials Committee may also recommend that appointment be granted for a period of less than two years in order to permit closer monitoring of an individual's compliance with any conditions.

(e) If the recommendation of the Credentials Committee is delayed longer than 60 days, the Chair of the Credentials Committee shall send a letter to the applicant, with a copy to the Medical Staff Executive Committee and the Chief Executive Officer, explaining the reasons for the delay.

3.A.7. Medical Staff Executive Committee Procedure:

(a) At its next regular meeting after receipt of the written findings and recommendation of the Credentials Committee, the Medical Staff Executive Committee shall:

(1) adopt the findings and recommendation of the Credentials Committee as its own; or

(2) refer the matter back to the Credentials Committee for further consideration and responses to specific questions raised by the Medical Staff Executive Committee prior to its final recommendation; or

(3) state its reasons in its report and recommendation, along with supporting information, for its disagreement with the Credentials Committee's recommendation.

(4) report to Board using such grouping and criteria as the Board may specify.

(b) If the recommendation of the Medical Staff Executive Committee is to appoint, the recommendation shall be forwarded to the Board through the Chief Executive Officer.

(c) If the recommendation of the Medical Staff Executive Committee would entitle the applicant to request a hearing, the Medical Staff Executive Committee shall forward its recommendation to the Chief Executive Officer, who shall promptly send Notice to the applicant. The Chief Executive Officer shall then hold the application until after the applicant has completed or waived a hearing and appeal.

3.A.8. Board Action:

(a) The Board may delegate to a committee, consisting of at least two Board members, action on appointment, reappointment, and clinical privileges if there has been a favorable recommendation from the Credentials Committee and the Medical Staff Executive Committee and there is no evidence of any of the following:

(1) a current or previously successful challenge to any license or registration;
(2) an involuntary termination, limitation, reduction, denial, or loss of appointment or privileges at any other hospital or other entity; or
(3) a trend of adverse judgments in professional liability actions.

Any decision reached by the Board committee to appoint shall be effective immediately and shall be forwarded to the Board for ratification at its next meeting.

(b) When there has been no delegation to a Board committee, upon receipt of a recommendation that the applicant be granted appointment and clinical privileges, the Board may:

(1) appoint the applicant and grant clinical privileges as recommended; or
(2) refer the matter back to the Credentials Committee or Medical Staff Executive Committee or to another source inside or outside the Hospital for additional research or information; or
(3) reject or modify the recommendation.

(c) If the Board determines to reject a favorable recommendation, it should first discuss the matter with the Chairs of the Credentials Committee and Medical Staff Executive Committee. If the Board's determination remains unfavorable to the applicant, the Chief Executive Officer shall promptly send Notice to the applicant that the applicant is entitled to request a hearing.

3.A.9. Time Periods for Processing:

Once an application is deemed complete, it is expected to be processed within 120 days, unless it becomes incomplete. This time period is intended to be a guideline only and shall not create any right for the applicant to have the application processed within this precise time period.

3.B. PROVISIONAL STATUS

3.B.1. Duration of Provisional Period:

(a) All initial appointments to the Medical Staff (regardless of the category of the staff) and all initial clinical privileges shall be provisional for a period of six months or longer, up to a maximum of 24 months, as recommended by the Credentials Committee.

(b) All grants of increased clinical privileges are also provisional. The duration and/or terms of this provisional period will be for the current appointment period unless otherwise recommended by the Credentials Committee, after consulting with the Service chief, and approved by the Board.

(c) During the provisional period, the individual shall be evaluated by the Service chief in which the individual has clinical privileges and by the relevant committees as to the individual's clinical competence and general behavior and conduct in the Hospital.

3.B.2. Duties of Provisional Appointees:

(a) The provisional appointee must arrange, or cooperate in the arrangement of, the required numbers and types of cases to be reviewed or observed by the Service chief or his or her designated observers.

(b) If the provisional appointee fails to fulfill all requirements of appointment relating to meeting attendance, completion of medical records, and/or cooperation with monitoring or observation conditions, at the expiration of provisional appointment, all clinical privileges shall be automatically relinquished. The individual may reapply for initial appointment in the future. Whenever provisional appointment or provisional clinical privileges are terminated, revoked, or restricted for other reasons, the individual shall be entitled to a hearing and appeal.

ARTICLE 4
CLINICAL PRIVILEGES

4.A. CLINICAL PRIVILEGES

4.A.1. General:

(a) Appointment or reappointment shall not confer any clinical privileges or right to practice at the Hospital.

(b) Each individual who has been appointed to the Medical Staff is entitled to exercise only those clinical privileges specifically granted by the Board.

(c) The granting of clinical privileges includes responsibility for emergency service call established to fulfill the Hospital's responsibilities under either the Emergency Medical Treatment and Active Labor Act or other applicable requirements or standards.

(d) In order for a request for privileges to be processed, the applicant must satisfy any applicable eligibility criteria.

(e) Requests for clinical privileges that are subject to an exclusive contract will not be processed except as consistent with applicable contracts.

(f) The clinical privileges recommended to the Board shall be based upon consideration of the following:

(1) the applicant's education, training, experience, demonstrated current competence and judgment, references, utilization patterns, and ability to perform the privileges requested competently and safely;

(2) availability of qualified staff appointees to provide coverage in case of the applicant's illness or unavailability;

(3) adequate professional liability insurance coverage for the clinical privileges requested;

(4) the Hospital's available resources and personnel;

(5) any previously successful or currently pending challenges to any licensure or registration, or the voluntary or involuntary relinquishment of such licensure or registration;

(6) any information concerning professional review actions or voluntary or involuntary termination, limitation, reduction, or loss of appointment or clinical privileges at another hospital; and

(7) other relevant information, including a written report and findings by the chief of each of the clinical services in which privileges are sought.

(g) The applicant has the burden of establishing qualifications and current competence for all clinical privileges requested.

(h) The report of the chief of the clinical service in which privileges are sought shall be forwarded to the Credentials Committee and processed as a part of the initial application for staff appointment.

(i) During the term of appointment, an appointee may request increased privileges by applying in writing. The request shall state the specific additional clinical privileges requested and information sufficient to establish eligibility, as specified in applicable criteria. If the individual is eligible and the application is complete, it shall be processed in the same manner as an application for initial clinical privileges.

4.A.2. Voluntary Relinquishment of Privileges:

(a) A Medical Staff Appointee may request voluntary relinquishment of clinical privileges by submitting a written request to the Medical Staff Executive Committee specifying the clinical privilege(s) to be relinquished and the reasons for the request.

(b) The Medical Staff Executive Committee may request a meeting with the Appointee involved if the decrease of the clinical privileges would create a burden on the on-call rotation. The Medical Staff Executive Committee shall make a recommendation to the Board.

(c) The Board shall make a final decision on the request, based upon, among other factors, how the request will affect the Hospital's ability to comply with applicable regulatory requirements, including but not limited to the Emergency Medical Treatment and Active Labor Act. The Board's decision shall be reported in writing by the Chief Executive Officer, or designee, to the Appointee, and the Medical Staff Executive Committee. If the Board permits the relinquishment of privileges, it shall specify the effective date of the relinquishment.

(d) Failure of an Appointee to request relinquishment of clinical privileges as set forth above shall result in the Appointee being maintained on the call schedule without any change to his or her call responsibilities.

(e) Appointees who have voluntarily limited their practice to include less than so-called "core" privileges typically associated with their Service may be required to participate in a general on-call schedule and to maintain sufficient competence to fulfill this responsibility or arrange for appropriate coverage.

4.A.3. Clinical Privileges for New Procedures:

(a) Requests for clinical privileges to perform a significant procedure or service not currently being performed at the Hospital (or a significant new technique to perform an existing procedure (either being a "New Procedure")) will not be processed until (1) a determination has been made that the procedure will be offered by the Hospital and until (2) criteria to be eligible to request those clinical privileges have been established.

(b) The Credentials Committee and the Medical Staff Executive Committee shall make a preliminary recommendation as to whether the new procedure should be offered, considering whether the Hospital has the capabilities, including support services, to perform the New Procedure.

(c) If it is recommended that the New Procedure be offered, the Credentials Committee shall conduct research and consult with experts, including those on the Medical Staff and those outside the Hospital, and develop recommendations regarding (1) the minimum education, training, and experience necessary to perform the new procedure, and (2) the extent of monitoring and supervision that should occur if the privileges are granted. The Credentials Committee may also develop criteria and/or indications for when the New Procedure is appropriate. The Credentials Committee shall forward its recommendations to the Medical Staff Executive Committee, which shall review the matter and forward its recommendations to the Board for final action.

4.A.4. Clinical Privileges That Cross Specialty Lines:

(a) Requests for clinical privileges, not currently on existing privilege lists, that traditionally at the Hospital have been exercised only by individuals from another specialty will not be processed until the steps outlined in this Section have been

completed and a determination has been made regarding the individual's eligibility to request the clinical privileges in question.

(b) The Credentials Committee shall conduct research and consult with experts, including those on the Medical Staff (e.g., Service chiefs, individuals on the Medical Staff with special interest and/or expertise) and those outside the Hospital (e.g., other hospitals, residency training programs, specialty societies).

(c) The Credentials Committee shall develop recommendations regarding (1) the minimum education, training, and experience necessary to perform the clinical privileges in question, and (2) the extent of monitoring and supervision that should occur. These recommendations may or may not permit individuals from different specialties to request the privileges at issue. The Credentials Committee shall forward its recommendations to the Medical Staff Executive Committee, which shall review the matter and forward its recommendations to the Board for final action.

4.A.5. Clinical Privileges After Age 70:

(a) On an annual basis, the Credentials Committee shall specifically evaluate the mental and physical capabilities of each appointee who has attained the age of 70 years and who is either admitting or caring for patients at the Hospital. Recommendations to the Credentials Committee for continued clinical privileges between ages 70 and 75 will be based upon such evaluations. Such evaluation will normally occur upon reappointment, but, as in the case of all persons appointed to the Medical Staff, may occur at any time during the appointment year if warranted. The Credentials Committee shall submit a report of its evaluation to the Medical Staff Executive Committee, and the Medical Staff Executive Committee shall submit a recommendation to the Board.

(b) Upon attaining the age of 75, Medical Staff appointees shall ordinarily no longer have privileges to admit or care for patients at the Hospital unless an exception for continuing privileges is recommended by the Credentials and Medical Staff Executive Committees and approved by the Board.

4.A.6. Clinical Privileges for Dentists and Oral and Maxillofacial Surgeons:

(a) The scope and extent of surgical procedures that a dentist or an oral and maxillofacial surgeon may perform in the Hospital shall be delineated and recommended in the same manner as other clinical privileges.

(b) Surgical procedures performed by dentists or oral and maxillofacial surgeons shall be under the overall supervision of the Service chief of the Surgery Service. A medical history and physical examination of the patient shall be made and recorded by a physician who is an Appointee to the Medical Staff before dental surgery shall be performed (with the exception of (c) below), and a designated physician shall be responsible for the medical care of the patient throughout the period of hospitalization.

(c) Oral and maxillofacial surgeons who admit patients without underlying health problems may perform a complete admission history and physical examination and assess the medical risks of the procedure on the patient if they are deemed qualified to do so by the Credentials Committee and Medical Staff Executive Committee.

(d) The dentist or oral and maxillofacial surgeon shall be responsible for the dental care of the patient, including the dental history and dental physical examination, as well as all appropriate elements of the patient's record. Dentists and oral and maxillofacial surgeons may write orders within the scope of their license and consistent with the Medical Staff Rules and Regulations and in compliance with the Hospital and Medical Staff Bylaws and this Policy.

4.A.7. House Staff:

(a) House Staff in training at the Hospital shall not hold appointments to the Medical Staff and shall not be granted specific clinical privileges; rather, they shall be permitted to exercise only those privileges set out in training protocols developed by residency programs.

(b) The protocols will delineate the roles, responsibilities, and patient care activities of the House Officers, including which House Officers may write patient care orders, under what circumstances they may do so and what entries a supervising physician must countersign. The protocol will also describe the mechanisms through which

physicians supervising House Officers shall make decisions about House Officer's progressive involvement and independence in delivering patient care. It shall be clearly understood that any medical activities performed by a House Officer in training at the Hospital shall be under the supervision of a Medical Staff Appointee. Clinical activities shall be no greater than to those of the clinical accorded to the supervising Medical Staff Appointee. Physicians taking advanced training outside of a formal fellowship may apply for membership to the Medical Staff, and with privileges for the purpose of such training and if appropriate so limited or conditioned.

(c) "Temporary Duty Physicians" shall consist of House Officers who are working outside their authorized training program. These physicians must currently be enrolled in at least the second year of an accredited residency program and will have a permanent license in the State of Nebraska and have adequate liability coverage. The House Officer's program director must acknowledge in writing that he/she is aware that the resident is engaging in work outside of his or her authorized training program. Temporary Duty Physicians shall not be eligible to vote, to hold office, or to serve on standing Medical Staff committees and shall not be considered members of the Medical Staff. Temporary Duty Physicians are required to complete applications, which will be reviewed by the Credentials Committee, the Medical Staff Executive Committee and the Board.

(d) The graduate medical education director or committee supervising the House Officer will communicate with the Medical Staff Executive Committee and the Board about the performance of the House Officer, patient safety issues, and quality of patient care.

4.B. TEMPORARY CLINICAL PRIVILEGES

4.B.1. Eligibility to Request Temporary Clinical Privileges:

(a) Temporary privileges may be granted by the Chief Executive Officer, or designee after consultation with the Service chief, the chair of the Credentials Committee and the Chief of Staff, only:

(1) when there is an important patient care need that requires immediate authorization to practice. Specifically, temporary privileges may be granted for: (i) the care of a specific patient; (ii) an individual serving as a locum tenens for Appointees to the Medical Staff; or (iii) the purpose of proctoring or teaching; or

(2) when an applicant for initial appointment is awaiting review by the Medical Staff Executive Committee and Board, following a favorable recommendation of the Credentials Committee, and has no current or previously successful challenges to his or her licensure or registration and has not been subject to involuntary termination of Medical Staff membership, or involuntary limitation, reduction, denial, or loss of clinical privileges, at another health care facility, but only if the Chief Executive Officer, or designee, makes a specific finding that an important or unusual need of the Hospital will be met by a grant of temporary privileges.

(b) The Chief Executive Officer, or designee shall verify appropriate information regarding the individual's licensure, DEA registration, current clinical competence and judgment, character, ethical standing, behavior, ability to safely and competently exercise the privileges requested, lack of Medicare/Medicaid/other government health care program exclusion/sanctions and professional liability insurance coverage and shall query the National Practitioner Data Bank before making a final decision to grant temporary privileges.

(c) Prior to temporary privileges being granted, the individual must agree in writing to be bound by the Bylaws, Rules and Regulations, Policies, procedures and protocols of the Medical Staff and the Hospital.

(d) Temporary privileges shall be granted for a specific period of time, as warranted by the situation. In no situation should the initial grant of temporary privileges be for a period exceeding 120 days.

(e) Temporary privileges shall expire at the end of the time period for which they are granted.

4.B.2. Supervision Requirements:

In exercising temporary privileges, the individual shall act under the supervision of the Service chief of the appropriate Service. Special requirements of supervision and reporting may be imposed on any individual granted temporary clinical privileges.

4.B.3. Termination of Temporary Clinical Privileges:

(a) The Chief Executive Officer may, at any time after consulting with the Chief of Staff, the Chair of the Credentials Committee, or the service chief, terminate temporary admitting privileges. Where temporary clinical privileges shall be granted for care of a specific patient, such privileges shall be terminated when the individual's inpatients are discharged.

(b) If the care or safety of patients might be endangered by continued treatment by the individual granted temporary privileges, the Chief Executive Officer, the Service chief, or the Chief of Staff may immediately terminate all temporary privileges. The Service chief or the Chief of Staff shall assign to another Appointee to the Medical Staff responsibility for the care of such individual's patients until they are discharged. Whenever possible, consideration shall be given to the wishes of the patient in the selection of a substitute physician.

(c) The granting of temporary privileges is a courtesy and may be terminated for any reason.

(d) Neither the denial nor termination of temporary privileges shall entitle the individual to a hearing or appeal.

4.C. EMERGENCY SITUATIONS

(1) For the purpose of this section, an "emergency" is defined as a condition which could result in serious or permanent harm to a patient(s) and in which any delay in administering treatment would add to that harm.

(2) In an emergency situation, an Appointee to the Medical Staff may administer treatment to the extent permitted by his or her license, regardless of Service status or specific grant of clinical privileges. Similarly, in an emergency situation, any practitioner who is not currently appointed to the Medical Staff may administer treatment to the extent permitted by his or her license.

(3) When the emergency situation no longer exists, the patient shall be assigned by the Service chief or the Chief of Staff to an Appointee with appropriate clinical privileges, considering the wishes of the patient.

4.D. DISASTER PRIVILEGES

In the event of a mass disaster, when the Hospital's emergency management plan has been activated, Medical Staff Appointees and employees may not be able to provide all the care required by individuals seeking treatment at our facilities. During these situations, the organization may be unable to complete the usual process to credential and privilege practitioners, and may implement a modified process. Under such circumstances, the Chief Executive Officer or the Chief of Staff is authorized to grant disaster privileges or permission to treat patients to volunteer physicians, nurses, and other professionals upon receipt of satisfactory evidence that such individuals are currently licensed in some state or otherwise capable of providing services to patients. The option to grant disaster privileges to volunteer practitioners is made on a case-by-case basis in accordance with the needs of the organization and its patients, and on the qualifications of its volunteer practitioners. Volunteers who are granted disaster privileges will be assigned to a peer in the same discipline to provide oversight of their professional performance during this period. Volunteers considered eligible to act as licensed independent practitioners in the organization must at a minimum present a valid government-issued photo identification issued by a state or federal agency and at least one of the following: a current picture hospital ID card that clearly identifies professional designation; a current license to practice; primary source verification of the license; identification indicating that the individual is a member of a Disaster Medical Assistance Team

(DMAT) or MRC, ESAR-VHP, or other recognized state or federal organizations or groups; identification indicating that the individual has been granted authority to render patient care, treatment and services in disaster circumstances; or identification by current hospital or medical staff member(s) who possesses personal knowledge regarding the volunteer's ability to act as a licensed independent practitioner during a disaster. Furthermore, notwithstanding any existing delineation of privileges or scope of authority, during a mass disaster Medical Staff Appointees, employees and volunteers are authorized to take whatever steps they reasonably believe are necessary to save or preserve the life or health of patients or to protect the public health. Primary source verification of licensure will begin as soon as the immediate situation is under control and will be completed within 72 hours from the time the volunteer practitioner presents to the organization.

4.E. CONTRACTS FOR SERVICES

(1) From time to time, the Hospital may enter into contracts with physicians and/or groups of physicians for the performance of clinical and/or administrative services at the Hospital. All individuals functioning pursuant to such contracts shall obtain and maintain Medical Staff appointment and/or clinical privileges at the Hospital, in accordance with the terms of this Policy.

(2) To the extent that any such contract confers the exclusive right to perform specified services at the Hospital on the other party to the contract, no other person may exercise clinical privileges to perform the specified services while the contract is in effect, other than as determined by the terms of such contract or by the Board.

(3) If any such exclusive contract would have the effect of preventing an existing Medical Staff Appointee from exercising clinical privileges that had previously been granted, the affected Appointee shall be given notice of the exclusive contract and have the right to meet with the Board or a committee designated by the Board to discuss the matter prior to the effective date of the contract in question. At the meeting, the affected Appointee shall be entitled to present any information relevant to the decision to enter into the exclusive contract. That individual shall not be entitled to any other procedural rights with respect to the decision or the effect of the contract on his/her clinical privileges, notwithstanding any other provision of this Policy. The inability of a physician to exercise clinical privileges because of an exclusive contract is not a matter that requires a report to the state licensure board or to the National Practitioner Data Bank.

(4) In the event of any conflict between this Policy or the Medical Staff Bylaws and the terms of any contract, the terms of the contract shall control.

ARTICLE 5

PROCEDURE FOR REAPPOINTMENT

5.A. PROCEDURE FOR REAPPOINTMENT

All terms, conditions, requirements, and procedures relating to initial appointment shall apply to continued appointment and clinical privileges and to reappointment.

5.A.1. Eligibility for Reappointment:

To be eligible to apply for reappointment and renewal of clinical privileges, an individual must have, during the previous appointment term:

(a) completed all medical records;

(b) completed all continuing medical education requirements;

(c) satisfied all Medical Staff responsibilities, including payment of dues and assessments;

(d) continued to meet all qualifications and criteria for appointment and the clinical privileges requested;

(e) had sufficient patient contacts to enable the assessment of current clinical judgment and competence for the privileges requested. Any individual seeking reappointment who has minimal activity at the Hospital must submit such information as may be requested (such as a copy of his/her confidential quality profile from his or her primary hospital, clinical information from the individual's private office practice and/or a quality profile from a managed care organization), before the application will be considered complete and processed further; and

5.A.2. Factors for Evaluation:

The following factors will be evaluated as part of the reappointment process:

(a) current clinical competence, judgment and technical skill in the treatment of patients;

(b) compliance with the Bylaws, Rules and Regulations, and policies of the Medical Staff and the Hospital;

(c) participation in Medical Staff duties, including committee assignments and emergency call;

(d) behavior at the Hospital, including cooperation with Medical Staff and Hospital personnel as it relates to patient care, the orderly operation of the Hospital, and ability to work with others;

(e) use of the Hospital's facilities for patients, taking into consideration practitioner-specific information compared to aggregate information concerning other individuals in the same or similar specialty; provided that, other practitioners shall not be identified;

(f) current ability to safely and competently exercise the clinical privileges requested and perform the responsibilities of staff appointment;

(g) capacity to satisfactorily treat patients as indicated by the results of the Hospital's performance improvement and professional and peer review activities;

(h) appropriate resolution of any verified complaints received from patients or staff; and

(i) other reasonable indicators of continuing qualifications.

5.A.3. Reappointment Application:

(a) An application for reappointment shall be furnished to Appointees at least four months prior to the expiration of their current appointment term. A completed reappointment application must be returned to Medical Staff Services within 30 days of its furnishing.

(b) Failure to submit a complete application prior to the expiration of the appointee's current term shall result in automatic expiration of appointment and clinical privileges at the end of the then current term of appointment.

(c) Reappointment shall be for a period of not more than two years.

(d) If an application for reappointment is submitted timely, but the Board has not acted on it prior to the expiration of the current term, the Chief Executive Officer shall have the authority to grant the individual temporary clinical privileges until such time as the Board can act on the application. The temporary clinical privileges shall be only for a period not to exceed 120 days.

(e) In the event the applicant for reappointment is the subject of an investigation or hearing at the time reappointment is being considered, a conditional reappointment for a period of less than two years may be granted pending the completion of that process.

(f) The application will be reviewed by Medical Staff Services to determine that all questions have been answered and that the individual satisfies all eligibility criteria for reappointment and for the clinical privileges requested.

(g) Medical Staff Services shall oversee the process of gathering and verifying relevant information and shall be responsible for confirming that all relevant information has been received.

5.A.4. Processing Applications for Reappointment:

(a) Medical Staff Services shall forward the application to the relevant Service chief and the application for reappointment shall be processed in a manner consistent with applications for initial appointment, except that applications for reappointment and renewal of clinical privileges shall not be eligible for the expedited process. Applications for reappointment and renewal of clinical privileges shall instead be processed through the Credentials Committee and the Medical Staff Executive Committee.

(b) If it becomes apparent to the Credentials Committee or the Medical Staff Executive Committee that it is considering a recommendation to deny reappointment or a requested change in staff category, or to reduce clinical privileges, the chair of either such committee may notify the individual of the general tenor of the possible recommendation and invite the individual to meet prior to any final recommendation being made. At the meeting, the individual should be informed of the general nature of the information supporting the recommendation contemplated and shall be invited to discuss, explain or refute it. This meeting is not a hearing, and none of the procedural rules for hearings shall apply. The committee shall indicate as part of its report whether such a meeting occurred and shall include a summary of the meeting with its minutes.

5.A.5. Time Periods for Processing:

Once an application is deemed complete, it is expected to be processed within 120 days, unless it becomes incomplete. This time period is intended to be a guideline only and shall not create any right for the applicant to have the application processed within this precise time period.

ARTICLE 6

LEAVES OF ABSENCE

6.A. LEAVES OF ABSENCE

(1) An individual appointed to the Medical Staff may request a leave of absence by submitting a written request to the Chief Executive Officer. The request must state the beginning and ending dates of the leave, which shall not exceed one year, and the reasons for the leave. Any absence from Medical Staff and/or from patient care responsibilities for longer than 60 days shall require an individual to request a leave of absence.

(2) The Medical Staff Executive Committee will determine whether a request for a leave of absence shall be granted. In determining whether to grant a request, the Medical Staff Executive Committee shall consult with the Chief of Staff and the Chief Medical Officer and the relevant Service chief.

(3) During the leave of absence, the individual shall not exercise any clinical privileges. In addition, the individual shall be excused from all Medical Staff responsibilities (e.g., meeting attendance, committee service, emergency service call obligations) during this period.

(4) No later than 30 days prior to the conclusion of the leave of absence, the individual shall request reinstatement by providing to Medical Staff Services a written summary of professional activities during the leave of absence. Medical Staff Services shall refer the matter to the Credentials Committee who will make recommendation to the Medical Staff Executive Committee who will make a recommendation to the Board. The individual bears the burden of providing information sufficient to demonstrate current competence and all other applicable qualifications.

(5) If the leave of absence was for health reasons, the request for reinstatement must be accompanied by a report from the individual's physician indicating that the individual is physically and/or mentally capable of resuming a hospital practice and safely exercising the clinical privileges requested.

(6) The Board shall consider the recommendations of the Medical Staff Executive Committee and may approve reinstatement to the same or a different staff category and may limit or modify the individual's clinical privileges. In the event the Board determines to take action that would entitle the individual to request a hearing, the individual shall be given special notice.

(7) Absence for longer than one year shall result in automatic relinquishment of Medical Staff appointment and clinical privileges unless an extension is granted by the Board. Extensions will be considered only in extraordinary cases where the extension of a leave is in the best interests of the Hospital.

(8) If an individual's current appointment is due to expire during the leave, the individual must apply for reappointment, or appointment and clinical privileges shall lapse at the end of the appointment period.

(9) Leaves of absence are matters of courtesy, not of right. In the event that it is determined that an individual has not demonstrated good cause for a leave, or where a request for extension is not granted, the determination shall be final, with no recourse to a hearing and appeal.

ARTICLE 7
HISTORY AND PHYSICALS

7.A. INPATIENT AND AMBULATORY SURGERY

(1) All patients admitted to the hospital (inpatient and 23-hour observation status) will have a complete history and physical examination within 24 hours of admissions. All patients shall have a completed history and physical examination, appropriate to the service, recorded prior to any invasive procedure or procedure in the operating room, except in an emergency in which a brief, written history and physical examination shall be recorded. If the history and physical examination is not available, the procedure shall be delayed. One-day stays must also have a dictated/written history and physical.

(2) The history includes:

a. The chief complaint

b. Details of the present illness

c. Allergies

d. Relevant past, social, and family histories appropriate to the age of the patient

e. Inventory of body systems.

(3) The physical examination report shall reflect:

a. A comprehensive current physical examination

b. Conclusions or impressions drawn from the history and physical to include:

i. Provisional diagnoses or problems to be addressed

ii. Statement of the anticipated course of action for the patient.

(4) All records must document evident of the following, as appropriate:

a. A medical history and physical examination completed no more than 30 days before or 24 hours after admission. The medical history and physical examination must be placed in the patient's medical record within 24 hours after admission.

b. If a patient's history and physical is completed before admission to the hospital, an updated examination must be completed and documented in the progress notes or a short clinical note in the patient's medical record within 24 hours after admission, but before a surgical procedure.

(5) Histories and physicals completed within 30 days prior to admission or ambulatory surgery by clinicians who are not credentialed by The Nebraska Medical Center must be affirmed in writing by the attending physician and/or anesthesiologist for both inpatients and outpatients. A durable legible copy may be used. These history and physicals will be included as part of the legal medical record.

(6) Obstetrical records include all prenatal information. A legible copy of office prenatal records is acceptable.

ARTICLE 8

CONFIDENTIALITY AND PEER REVIEW PROTECTION

8.A. CONFIDENTIALITY

Actions taken and recommendations made pursuant to this Policy shall be strictly confidential. Individuals participating in peer review activities shall make no disclosures of any such information (discussions or documentation) outside of peer review committee meetings, except:

(1) when the disclosures are to another authorized appointee of the Medical Staff or authorized Hospital employee and are for the purpose of conducting legitimate peer review activities; or

(2) when the disclosures are authorized, in writing, by the Chief Executive Officer or by legal counsel to the Hospital.

Any breach of confidentiality may result in a professional review action and/or appropriate legal action.

(3) In accordance with the law of the State of Nebraska.

8.B. PEER REVIEW PROTECTION

(1) All peer review activities pursuant to this Policy and related Medical Staff documents shall be performed by peer review committees in accordance with applicable state law. Peer review committees include, but are not limited to:

(a) all standing and ad hoc Medical Staff and Hospital committees;

(b) hearing panels;

(c) the Board and its committees;

(d) any individual acting for or on behalf of any such entity, including but not limited to service chiefs, division coordinators, committee chairs and members, officers of the Medical Staff, and experts or consultants retained to assist in peer review activities; and

(e) all services and divisions.

All reports, recommendations, actions, and minutes made or taken by peer review committees are confidential and covered by the provisions of applicable state law.

(2) All peer review committees shall also be deemed to be "professional review bodies" as that term is defined in the Health Care Quality Improvement Act of 1986, 42 U.S.C. ' 11101 *et seq.*

ARTICLE 9

AMENDMENTS

(1) This Policy may be amended by a majority vote of the members of the Medical Staff Executive Committee present and voting at any meeting of that committee where a quorum exists, provided that the written recommendations of the Bylaws Committee concerning the proposed amendments shall have first been received and reviewed by the Medical Staff

Executive Committee. Notice of all proposed amendments shall be posted on the Medical Staff bulletin board at least 14 days prior to the Medical Staff Executive Committee meeting and any appointee to the Medical Staff may submit written comments to the Medical Staff Executive Committee. No amendment shall be effective unless and until it has been approved by the Board.

(2) This Policy may also be amended by the Board on its own motion provided that any such amendment is first submitted to the Bylaws and Medical Staff Executive Committees for their review and comment at least 30 days prior to any final action by the Board on such amendment, but only in instances where amendments must be made in order (1) to comply with state licensure requirements, Joint Commission Accreditation Standards, and the Medicare Conditions of Participation for Hospitals; or (2) to respond to changes in any federal or state law that would affect this institution.

ARTICLE 10
ADOPTION

This Policy is adopted and made effective upon approval of the Board, superseding and replacing any and all other Bylaws, Rules and Regulations of the Medical Staff or Hospital policies pertaining to the subject matter thereof.

Adopted by the Medical Staff:

October 21, 2009 _____

Chief of Staff

Approved by the Board:

September 21, 2009 _____

Chairperson, Board of Directors